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Kinder v. Geithner - Commonwealth of Massachusetts Amicus Brief

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[ORAL ARGUMENT NOT YET SCHEDULED]

No. 11-1973

United States Court of Appeals
for the Eighth Circuit

PETER KINDER, ET AL.,

Plaintiffs-Appellants,

v.

TIMOTHY F. GEITHNER, ET AL.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MISSOURI (SIPPEL, J.)

AMICUS BRIEF OF THE COMMONWEALTH OF MASSACHUSETTS IN SUPPORT OF APPELLEES, SEEKING AFFIRMANCE

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INTEREST OF THE AMICUS

In the spring of 2006, the Commonwealth of Massachusetts passed and implemented *An Act Providing Access to Affordable, Quality, Accountable Health Care*, Chapter 58 of the Acts of 2006 ("Chapter 58"), thereby becoming the first State in the Nation to enact healthcare reform that requires all non-exempt individuals to purchase some form of health insurance coverage. Chapter 58's core features include, among other things, a state-operated health insurance exchange, new subsidies for low- and moderate-income individuals, and a mandate that all individuals who can afford health insurance purchase coverage. Chapter 58 has been widely cited as a model used by Congress in fashioning what became the Patient Protection and Affordable Care Act (the "ACA"). With four years of empirical data collected since Chapter 58 went into effect, Massachusetts is uniquely situated to speak to the actual economic effects of comprehensive reform that includes an individual coverage requirement.

The experience of Massachusetts under Chapter 58 confirms a key Congressional assumption underlying the ACA: that by requiring individuals to be insured, and thereby preventing healthy people from foregoing health insurance until they are sick or injured (a practice commonly derided as "free-riding"), a comprehensive reform program can spread risk, control costs, and reduce the financial burdens otherwise borne by health plans

and free-care pools. Massachusetts submits this amicus brief in support of the ACA because its experience demonstrates that Congress had a rational basis for concluding that free-riding by individuals, taken in aggregate, has a substantial effect upon interstate commerce, and that reducing or eliminating free-riding has a salutary impact on the health insurance market as a whole.

In July of 2005, then Governor Mitt Romney filed House Bill 4279, and in his filing letter to the Massachusetts Legislature he stated:

> Today, we spend approximately $1 billion on the medical cost for the uninsured. Safety Net Care redirects this spending to achieve better health outcomes in a more cost-effective manner. With Safety Net Care in place, it is fair to ask all residents to purchase health insurance or have the means to pay for their own care. This personal responsibility principle means that individuals should not expect society to pay for their medical costs if they forego affordable health insurance options.[1]

Governor Romney's proposed legislation to enact "Safety Net Care" was the precursor to Chapter 58, which he signed on April 12, 2006.[2]

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[1] Letter from Governor Mitt Romney to the Massachusetts Legislature dated July 20, 2005, filing proposed health reform entitled, An Act to Increase the Availability and Affordability of Private Health Insurance To Residents of the Commonwealth. H.B. 4279, 184th Gen. Ct. (Mass. 2005)

[2] Under Governor Romney's proposed legislation, "Safety Net Care" was the term used for a proposed government subsidized premium

(footnote continued)

The Massachusetts healthcare reform law has yielded positive economic consequences. Three years after its enactment, Massachusetts had reduced the number of uninsured residents to less than three percent of the state's population and increased the number of residents with health insurance by more than 432,000, giving Massachusetts the lowest percentage of uninsured residents in the Nation.[3] By the fall of 2009, more than 95 percent of nonelderly Massachusetts adults were insured, up from 87.5 percent in the fall of 2006.[4] The significant gains in the number of Massachusetts residents with health insurance helped spur a corresponding sharp decline in the amount of state spending on "free care" for the uninsured and under-insured.

(footnote continued)
assistance offered to low-income individuals who were not eligible for Medicaid. H.B. 4279, 184th Gen. Ct. (Mass. 2005).

[3] See Mass. Taxpayers Found., Massachusetts Health Reform: The Myth of Uncontrolled Costs 2 (May 2009), available at http://www.masstaxpayers.org/sites/masstaxpayers.org/files/Health%20care-NT.pdf [hereinafter Mass. Taxpayers Found.].

[4] See Blue Cross Blue Shield Found., Health Reform in Massachusetts: An Update as of Fall 2009 iv (June 2010), available at http://bluecrossfoundation.org/~/media/Files/Publications/Policy%20Publications/060810MHRS2009FINAL.pdf [hereinafter BCBS Found. Report]. Indeed, insurance coverage rose by 14.1 percentage points for lower-income adults and 6.6 percentage points for adults with a chronic health condition between fall 2006 and fall 2009. Id. at v.

The dollar value of free care provided dropped from $709.5 million in fiscal year 2006 to $414 million in fiscal year 2009.[5]

Despite these successes under Chapter 58, however, Massachusetts, like any individual state, is unable to grapple effectively with the interstate (and international) economic implications of current healthcare trends. While Massachusetts plays the primary role in protecting the health and welfare of Massachusetts residents, the state shares responsibility for regulating healthcare and health insurance with the federal government. Through Medicare, Medicaid, and a variety of federal statutes, notably the Employee Retirement Income Security Act of 1974 (ERISA), the federal government plays a substantial (and, in some areas, exclusive) role in shaping the nationwide healthcare marketplace. Given this overlay, some aspects of healthcare reform are beyond individual states' regulatory reach. For example, Massachusetts's ability to regulate the private group health plan market in Massachusetts is constrained by ERISA, which preempts state governments from enacting laws that regulate self-insured employer health benefit plans, the most common source of health coverage for American workers.

[5] See Division of Health Care Finance and Policy, 2009 Annual Report: Health Safety Net 4 (Dec. 2009); Division of Health Care Finance and Policy, Uncompensated Care Pool PFY06 Annual Report 3 (July 2007).

Accordingly, Massachusetts supports the ACA as an appropriate federal response to the urgent need for comprehensive, national healthcare reform. The ACA carefully balances federal economic interests with the states' interest in developing new ways to control costs while improving access to quality healthcare.

This amicus brief is filed by Martha Coakley, Attorney General of the Commonwealth of Massachusetts. As the Commonwealth's chief legal officer, General Coakley is expressly authorized by Massachusetts state law to participate in proceedings of this nature. See M.G.L. c. 12, § 3 ("The attorney general shall appear for the commonwealth . . . in all suits and other civil proceedings in which the commonwealth is . . . interested . . . in all the courts of the commonwealth . . . and in such suits and proceedings before any other tribunal.").

ARGUMENT[6]

A. THE EXPERIENCE OF MASSACHUSETTS CONFIRMS THAT CONGRESS HAD A RATIONAL BASIS TO DETERMINE THAT FREE-RIDING, TAKEN IN AGGREGATE, SUBSTANTIALLY AFFECTS INTERSTATE COMMERCE; ACCORDINGLY, CONGRESS HAD AUTHORITY UNDER THE COMMERCE CLAUSE TO IMPOSE THE MINIMUM COVERAGE REQUIREMENT.

The Commerce Clause provided Congress with authority to enact the ACA, including the minimum coverage requirement. The Constitution gives Congress the power to "regulate Commerce . . . among the several States." U.S. Const., art. I, § 8, cl. 3. Under this authority, Congress can "regulate activities that substantially affect interstate commerce."[7] Gonzales v. Raich, 545 U.S. 1, 17 (2005).

As "stressed" by the Supreme Court, "[i]n assessing the scope of Congress' authority under the Commerce Clause . . . the task before [the Court] is a modest one." Id. at 22. The Court

[6] Massachusetts notes that the District Court entered judgment in favor of the United States upon its conclusion that none of the plaintiff-appellees had standing to prosecute this litigation. In its opening brief, the United States asks this Court to affirm the District Court's dismissal for want of standing, but alternatively seeks affirmance on the merits, should this Court disagree with the District Court's analysis of the standing question. Massachusetts, as amicus curiae, takes no position on the standing issue, but rather directs its advocacy to the merits of the appellants' claims, in the event that this Court should reach them.

[7] Congress also has the authority to "regulate the channels of interstate commerce" and to "regulate and protect the instrumentalities of interstate commerce and persons or things in interstate commerce." Gonzales, 545 U.S. at 16-17.

"need not determine" itself whether the regulated "activities, taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." Id.

There is a rational basis for concluding that, taken in the aggregate, individuals' refusal to obtain health insurance substantially affects interstate commerce. "[T]he business of insurance" is within "the regulatory power of Congress under the Commerce Clause." United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 553 (1944). In the ACA, Congress found that:

> The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

ACA § 1501(a)(2)(F), as amended by § 10106.[8] "It is well established by decisions of [the Supreme] Court that the power to regulate commerce includes the power to regulate the prices at which commodities in that commerce are dealt in and practices affecting such prices." Wickard v. Filburn, 317 U.S. 111, 128

[8] Such Congressional findings are to be considered in the analysis when available, although they are not necessary to sustain the exercise of Commerce Clause authority. Gonzales, 545 U.S. at 21.

(1942) (upholding, as a proper subject of Congressional action under the Commerce Clause, a regulation penalizing production of wheat in excess of federal quota, even where applied to wheat grown not for market, but for consumption at home). Because it directly impacts the prices at which health insurance policies will be sold, individuals' refusal to obtain health insurance is a practice properly subject to regulation by Congress under the Commerce Clause.[9]

The experience in Massachusetts elevates the connection between eliminating free-riders and controlling costs from a rational belief to a demonstrable correlation. Governor Romney and the Massachusetts Legislature, like Congress, determined that an individual health insurance mandate, as part of a comprehensive reform package, would serve to increase access to healthcare while greatly decreasing the detrimental cost-shifting caused by people who chose to forego insurance and shift the cost of their current and future healthcare to others.[10] As discussed above, in the three years after Chapter

[9] As in Gonzales, 545 U.S. at 25-26, the earlier Supreme Court decisions in United States v. Lopez, 514 U.S. 549 (1995), and United States v. Morrison, 529 U.S. 598 (2000), are distinguishable as they relate to non-economic behavior.

[10] Federal law, in fact, requires Medicare-participating hospitals with an emergency department to provide emergency services to stabilize patients with emergency medical conditions

(footnote continued)

58's enactment, there was, indeed, a significant increase in the percentage of insured Massachusetts residents.[11] The significant gains in the number of Massachusetts residents with health insurance helped spur a corresponding sharp decline in the amount of spending on "free care" for the uninsured and under-insured: The amount of free care dropped 40 percent -- hundreds of millions of dollars -- from fiscal year 2006 to fiscal year 2009.[12]

The Massachusetts reform program also has improved healthcare use. From the fall of 2006 to the fall of 2009, more adults (including lower-income adults, adults with chronic health conditions and minority adults) reported visits to doctors and fewer adults reported unmet need for care.[13]

Massachusetts achieved these gains in access to care while making gains in the affordability of care for its residents. In the fall of 2009, as compared with the fall of 2006, and

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(footnote continued)
regardless of whether they are insured. See 42 U.S.C. § 1395dd (2006).

[11] See Mass. Taxpayers Found., supra note 3; BCBS Found. Report, supra note 4, at 10.

[12] See Division of Health Care Finance and Policy, 2009 Annual Report: Health Safety Net 4 (Dec. 2009); Division of Health Care Finance and Policy, Uncompensated Care Pool PFY06 Annual Report 3 (July 2007).

[13] BCBS Found. Report, supra note 4, at 10.

notwithstanding the systemic impacts of the economic recession, there were reductions in both the share of adults reporting high out-of-pocket healthcare spending relative to family income and the share of adults reporting unmet needs for care due to cost.[14] Moreover, nearly 200,000 of the state's newly insured residents were enrolled in private plans that do not receive government subsidies, evidence that the more generous public programs created under Chapter 58 are not supplanting the state's existing health insurance providers.[15] Analysis from 2009 also demonstrates that the state's individual health insurance requirement is encouraging people who were previously eligible for employer-based insurance, but did not previously accept it, to enroll in a private plan.[16]

As the experience with healthcare reform in Massachusetts shows, prohibiting people from opting out of the insurance market when they can afford coverage, and creating incentives for these "free-riders" to join their employer-sponsored health

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[14] BCBS Found. Report, supra note 4, at 10.

[15] See Josh Goodman, Massachusetts: A Model, or Cautionary Tale?, Wash. Health Pol'y Wk. in Rev. (The Commonwealth Fund), June 8, 2009, available at http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2009/Jun/June-8-2009/Massachusetts-A-Model-or-Cautionary-Tale.aspx.

[16] Id.

plan or to enroll in a publicly supported healthcare plan, has helped generate "increases in both public and private insurance coverage, and this increase in coverage has translated into increases in the access, use, affordability, and quality of care in the state."[17]

B. BECAUSE ELIMINATING FREE-RIDERS IS, AT A MINIMUM, RATIONALLY RELATED TO SUCCESSFUL IMPLEMENTATION OF OTHER COMPONENTS OF FEDERAL HEALTHCARE LAW, CONGRESS ALSO HAD AUTHORITY UNDER THE NECESSARY AND PROPER CLAUSE TO IMPOSE THE MINIMUM COVERAGE REQUIREMENT.

The Necessary and Proper Clause provided Congress with additional authority to set the minimum coverage requirement as a means to effectuate the broader ends of the ACA. The Constitution gives Congress the power to "make all Laws which shall be necessary and proper in carrying into Execution" its powers, including those under the Commerce Clause. U.S. Const., art. I, § 8, cl. 18.

As with the analysis under the Commerce Clause, the standard for determining whether legislation is authorized under the Necessary and Proper Clause is a relaxed one. Enactment of a particular federal law is authorized by the Necessary and Proper Clause when "the statute constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." United States v. Comstock, ___ U.S. ___, 130

[17] BCBS Found. Report, supra note 4, at 50.

S.Ct. 1949, 1956 (2010). In Comstock, the Court reiterated its nearly 200-year-old formulation on this issue, originally expressed by Chief Justice Marshall, that the Necessary and Proper Clause is a "broad power to enact laws that are 'convenient, or useful' or 'conducive' to the . . . 'beneficial exercise'" of specifically granted powers. 130 S.Ct. at 1956 (quoting McCulloch v. Maryland, 4 Wheat 316, 413, 418 (1819)).

Thus, even if Congress lacked authority under the Commerce Clause to impose the minimum coverage requirement -– which it did not; see Argument A, supra –- it was authorized by the Necessary and Proper Clause to impose it as a rational requisite of implementing other components of federal law that were unequivocally permitted by the Commerce Clause. Congress made particular findings that make clear the rational relationship between the minimum coverage requirement and Congress's exercise of its Commerce Clause powers in other related legislation. First, Congress found that:

> Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and [the ACA], the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

ACA § 1501(a)(2)(H), as amended by § 10106.

Second, Congress, in § 1201 of the ACA, makes changes to the Public Health Service Act that ban pre-existing condition exclusions and discrimination in health insurance based on health status. Congress found that:

> Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the [minimum coverage] requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold.

ACA § 1501(a)(2)(I), as amended by § 10106.

Massachusetts's experience gives additional support to the conclusion that the minimum coverage requirement was, at a minimum, rationally related to the implementation of Congress's unquestioned authority under the Commerce Clause to alter other aspects of the federal healthcare regulatory landscape. Specifically, as discussed above, Massachusetts utilized just such a provision as a linchpin of its comprehensive reform and has reaped intrastate benefits through sharp reductions in spending on "free care" for uninsured residents and improved access to healthcare.

There remains a limit, however, to the structural changes Massachusetts can effect in the healthcare marketplace, given

the constraints resulting from state jurisdictional limits and imposed by long-established federal law. Healthcare access and affordability significantly affect interstate activity, including where people choose to reside and how they obtain coverage and treatment. During fiscal year 2009 alone, for example, Massachusetts hospitals provided inpatient care to more than 43,000 patients who were not residents of Massachusetts, at an estimated cost of $910,000,000.[18] Of these non-Massachusetts residents, approximately 1,200 did not have any health insurance.[19] The number of out-of-state patients without insurance coverage was even greater at Massachusetts emergency departments where more than 12,900 uninsured individuals received care during fiscal year 2009.[20] Massachusetts cannot regulate insurance coverage for non-Massachusetts residents, nor can it (or should it) restrict access to necessary and emergent care. This interstate flow of patients (including uninsured patients) is but one illustration that individual states cannot effectively account for, let alone mitigate, the impact of healthcare trends felt on the national and interstate levels.

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[18] Division of Health Care Finance and Policy, Hospital Discharge Database (HDD) for fiscal year 2009 (October 1, 2008 through September 30, 2009).

[19] Id.

[20] Id.

Congress has long recognized that employer health plans had "operational scope and economic impact" that was "increasingly interstate."[21] The federal government already exercises significant control over a large section of the private group health plan market. In Massachusetts, more than half of this market is made up of self-insured plans that, because of ERISA's preemptive effect, are beyond the direct reach of state regulators.[22] Nationwide, the number of people enrolled in these self-insured employer plans has increased markedly since 1999. In 2007, 55 percent of the 132.8 million people in plans governed by ERISA were in self-insured plans, up from 44 percent in 1999.[23] The federal government has long exercised exclusive regulatory authority over these self-insured employer benefit plans. The continued growth of self-insured plans, coupled with the interstate nature of the healthcare marketplace, demonstrates the need for the federal reforms contained in the

[21] ERISA, Pub. L. No. 93-406, § 2.

[22] The "private group market" includes large group, small group, and self insured members. See Division of Health Care Finance and Policy, Health Care in Massachusetts: Key Indicators, 4, 6 (Nov. 2010), available at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/key_indicators_november_2010.pdf.

[23] See William Pierron & Paul Fronstin, ERISA Pre-emption: Implications for Health Reform and Coverage, 314 EBRI Issue Brief 11 (Feb. 2008), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf.

ACA to establish minimum national standards for health coverage. The ACA specifically provides that individual states remain free to further regulate intrastate aspects of the health insurance market, including reforms similar to those implemented in Massachusetts under Chapter 58, if they so choose.

The success of Massachusetts healthcare reform demonstrates the economic benefits of tackling the free-rider problem head-on, through comprehensive reform including a requirement that individuals who can afford health insurance must purchase it. The experience of Massachusetts shows that the minimum coverage requirement in the ACA was, at least, rationally related to Congress's effort pursuant to the Commerce Clause to address the interstate implications of healthcare access and affordability.

CONCLUSION

For these reasons, Massachusetts urges this Court to hold that Congress had the constitutional authority to enact the Patient Protection and Affordable Care Act.

Respectfully submitted,

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August 18, 2011

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the type-volume limitation set forth in Fed. R. App. P. 28.1(e) and 32(a)(7)(B). According to the word count provided in Microsoft Office Word 2007, which was the word-processing system used to prepare the brief, the foregoing brief contains 2,934 words. The text of the brief is composed in 12-point Courier New, a monospaced font having no more than 10.5 characters per inch.

/s/ Daniel J. Hammond
Daniel J. Hammond
Assistant Attorney General

CERTIFICATE OF SERVICE

I hereby certify that on August 18, 2011, I filed the foregoing Amicus Brief of the Commonwealth of Massachusetts in Support of Appellee via the ECF system for the Eighth Circuit Court of Appeals. I further certify that, once directed to do so by the Clerk of that Court, I will effect the filing of a paper version of this brief and the service of same upon all interested parties, pursuant to Local Rule 28A(d). I will file an additional certificate of service at that time.

/s/ Daniel J. Hammond
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